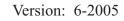
## Every Woman Matters

## Client Informed Refusal





Every Woman Matters P.O. Box 94817 Lincoln, NE 68509-4817

	I, have been informed by my doctor/health care gi that I should have this procedure/treatment below. This procedure is:									
uı										
_	(please)	print in you	ur own words, the no	ame of the pro	ocedure/trea	tment and why it is	being done)			
If	If I do not get this procedure/treatment I know these things will happen to me:									
	(please print in your own words what can happen if the procedure/treatment is not done)									
	<ul> <li>I have had the need for this procedure/treatment explained to me.</li> <li>I know that not having this procedure/treatment at this time, is against my doctor's advice a</li> </ul>									
	may be harmful to my health. My abnormality may lead to cancer if I do not have it done.  I know what this procedure/treatment is for. I know why I need it. I know how it is done.									
	■ I know that signing this form does not stop me from having this procedure/treatment done l									
•										
	-									
	Land Ciamatana						Doto	/	/	
C	lient Signature _						_ Date			
	ubmitted by:		Clinic			Case Manag	er	′		
							er			
			Clinic		0	Case Manag	er			
Su			Clinic Outreach Wo		0	Case Manag	er	'		
Sı	ubmitted by:	\rightarrow \right	Clinic Outreach Wo	rker	0	Case Manag EWM Centr	ger al Office			
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$\frac{1}{Na}$	ubmitted by:  une of Submitting Facility  Portion below	//Clinic/Ago	Clinic Outreach Wo	rker	nt unabl	Case Manag EWM Centr	ger ral Office r has lang	guage b	oarri	
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Su S	ubmitted by:  me of Submitting Facility  Portion below Cilient unable to y hould be signed by	//Clinic/Ago	Clinic Outreach Wo	ly if clier rself; the	nt unabl	Case Manag EWM Centr	r has lang	guage b	oarri	
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## Every Woman Matters Service Provider Documentation

Version: 6-2005

Provider has insured that the client has enough information to make an informed decision.										
Client Info	ormed Refusal given to client:	<u> </u>	In person Mail							
Client failed to return a signed Client Informed Refusal.										
Name of Facili	ity/Clinic/Agency		Date/							
Provider is	vere made to give information to the cl Diagnostic Services Diagnosis Treatment Services Treatment sunsure if the client has or is able to mowing reason(s):									
	No verbal communication with clier Low literacy level Language / Translation issues Mental / Emotional disability Visual / Hearting impairment	nt								
Name of Facili	ty/Clinic/Agency		Date//							